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STATEMENT BY

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Chairwoman Davis, Representative Wilson, and distinguished Members of the Military Personnel Subcommittee, thank you for the opportunity to discuss the organization of the Military Health System (MHS). First, I would like to publicly thank the Honorable S. Ward Casscells for his years of principled, passionate service as Assistant Secretary of Defense for Health Affairs. Dr. Casscells is a friend and mentor whom I greatly respect. His compassion and commitment to service members and families is unparalleled. He is one of my heroes, and I do not say that lightly. His team at Health Affairs (HA) and the TRICARE Management Activity (TMA) are hard-working, dedicated individuals. I salute their service to the Nation.

As the Army Surgeon General and Commander of the Army Medical Command (MEDCOM), I am very focused on my Title 10 responsibilities to support the Secretary of the Army and the Chief of Staff of the Army. The structure of the MHS is critical to the Army's ability to execute our mission effectively. The mission of Army Medicine is to:

- Promote, Sustain and Enhance Soldier Health
- Train, Develop and Equip a Medical Force that Supports Full Spectrum Operations
- Deliver Leading Edge Health Services to Our Warriors and Military Family to Optimize Outcomes

A structure that places execution within the Services and oversight within Health Affairs has served us well for many years. It is essential to the success of the Service Medical Departments and the MHS that HA work with the military Services to establish a strategic vision and direction for military medicine; ensure the viability of a robust direct care system; advocate for healthcare programs within the Department of Defense (DoD); serve as a policy developer and integrator across the Services; and operate in a transparent, open manner. In this structure, the Service Medical Departments must be given latitude to achieve their missions within the context of their Service identity and culture. It

is a delicate balance between Service autonomy and Departmental standardization and control. This balance is most easily achieved by ensuring that the Services remain the operational arm, while HA remains focused on policy and strategy.

Health Affairs currently operates a field activity—the TRICARE Management Activity (TMA)—and has other direct reporting organizations, such as the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. Recently, HA and TMA have begun assuming more control of operational activities at some risk to their strategic role. The Army Medical Department, acting on behalf of the Secretary of the Army, once exercised DoD Executive Agent responsibilities, functions, and authorities for 33 organizations. While some of these organizations have been absorbed into the US Army Medical Command, a number of them have become part of the HA/TMA organizational structure. As HA becomes more involved in maintaining operational control over an increasing array of subordinate operating activities, it appears to have become an increasing challenge for them to maintain focus on their strategic development and broad policy responsibilities. HA leaders operating in the execution lane are sometimes forced to compete alongside the Services for resources and appropriate attention. Many senior leaders of HA are dual-hatted as TMA leaders. This leads to the perception that TMA is an unequal stakeholder in the MHS, outweighing the influence of the Services, who have only their own vote. I am concerned that the role of the Services is diminished in many MHS forums because TMA is perceived as “first among equals.”

In short, the Services are executors of broad policy guidelines for Force Health Protection and the provision of healthcare services—we perform service-specific mission analysis of these broad guidelines; issue Army-, Navy-, and Air Force-specific orders; we execute these orders; we execute programs, and we execute the delivery of the health benefit. Health Affairs is best suited as a policy-making organization, providing oversight, leadership, and policy integration

to the Service Medical Departments and the TMA. Heath Affairs has been increasingly assuming roles and responsibilities that are more suited to the operational or execution level. I am concerned that this trend will obscure and minimize service-specific challenges in achieving desired clinical and programmatic outcomes and threaten the viability of the direct care system.

The Service Medical Departments interact daily with HA and our sister Services on committees and fora that allow us to discuss mutual areas of concern, share best practices, and move the MHS forward. One example is the Clinical Proponency Steering Committee, which provides a forum for best practices in the clinical arena. It is through this body that the Army presented findings and recommendations that led to the development of a comprehensive policy related to malaria prophylaxis.

In my opinion, HA is well-suited to its policy integrator role and should capitalize on this important role. Similarly, HA is well-suited to its strategic development role. Dr. Casscells and his leadership team recently reached out to the Services to request participation in the development of an MHS strategy, and I look forward to continuing our work with HA to build and communicate a clear, transparent, and understandable way ahead for the MHS.

In January of this year, Dr. Casscells solicited input from the Service Surgeons General regarding the year ahead for the MHS. I highlighted several areas where I felt that HA was best situated to assist the Services. Two of these topics have already been the subject of congressional hearings before this subcommittee.

1. Access to Care - As the individual accountable for the delivery of healthcare services for all components of the Army and DoD beneficiaries served by Army military treatment facilities (MTFs), access to care is my number one priority in the MEDCOM. Our patients are frustrated with not being able to see us in a timely and hassle-free manner. We must maximize the capacity of our installation MTFs and enroll beneficiaries to that capacity. Enrollment must be in balance with MTF capacity and is the foundation for meeting access to care standards. In addition to proper enrollment, I intend to improve access through

increased provider availability and beneficiary knowledge on how to obtain access. We will work to reduce friction at key access points, such as phone service, online appointments, and follow-up appointments. Additionally, we will relook clinic schedule management, improve accounting for all patients requiring access to primary care, and leverage the civilian network and technology. All of these efforts will be under command oversight, and will ultimately increase provider team continuity, decrease inappropriate utilization, simplify the appointment process, and improve communication through the use of the Electronic Health Record (EHR).

The Services control our part of the healthcare delivery system, but we do not control the TRICARE network. The TRICARE network exists to support and supplement the direct care system, not to compete against it. A robust and integrated TRICARE network is a requirement throughout the MHS; there is not a single Army MTF that provides all clinical services. This is so important that I have reorganized the MEDCOMs regional medical commands to be aligned with TRICARE Regional Offices and regions. This is intended to promote a more seamless delivery of care within these regions. TMA's oversight of the 3 regional contractors is crucial. The goal is for the care received, whether from the MTF or from the network, to be seamless. TMA and the TRICARE network must be responsive to the needs of the local MTF commander who is charged with overall responsibility for ensuring patients obtain the right care, at the right time, in the right venue. A collaborative approach led by HA in support of the direct care system can significantly improve access to care.

2. Leverage Information Technology (IT) - Crucial to the long-term sustainment of military medicine is the development and propagation of IT systems that support both clinical and business activities across the three services. For reasons of effectiveness and efficiency, HA needs to deliver IT systems to the Services so we can perform our mission. The creation of secure, integrated, dynamic IT systems will allow the MHS to operate in a more tri-service manner to leverage other federal agencies and tap into leading edge academic practices and research, which is necessary to improve overall MHS

performance, minimize IT costs, and reduce duplication of effort. This is the development of a "knowledge network"—the future of health improvement and healthcare delivery. HA's process for defining, funding, and altering IT system requirements should emphasize flexibility and responsiveness in responding to the Services' evolving needs. We must leverage technology to incorporate best practices from the public and private sectors with respect to health care purchasing, as well as managing the business of health care. We must provide timely, secure, standard, transparent, adaptable, affordable systems and processes that, in coordination with other elements, enable performance improvement, ensure healthy outcomes, and identify best practices across the MHS.

3. Electronic Health Record (EHR) - As discussed before this subcommittee last month, the MHS has been talking about creating a comprehensive EHR for a decade and poured a tremendous amount of money into it. We all recognize the vital and transformative role of an effective EHR in enabling our move into 21st Century military medicine. The MHS has made strategic progress toward this end, but our providers continue to be frustrated by the slow and cumbersome process of improving the system and making it easier to use at the provider-patient interface. HA's leadership and sustained effort is critical to turn our vision of an EHR into reality. But here again, HA's operational focus has self-admittedly distracted it from focusing on an overarching strategic plan. Our EHR should be compatible with the Department of Veterans Affairs and have an open-enough system architecture to be compatible with our network providers. The treatment received from the network needs to be incorporated into our EHR, and we need to improve our system for providing documentation to off-post providers when we see their patients in our MTFs. We need to establish firm goals, milestones, and penalties for the contractors we have hired to develop this system for us, and we need to hold them accountable. A comprehensive, globally available EHR will have a very strong impact on the practice of evidence-based medicine and assist tremendously with improving continuity of care by

improving the information flow between the various providers and facilities where our beneficiaries receive care.

4. Human Capital Management Strategy - We need to leverage Health Affairs to lead a dialogue with the Services and the Office of Personnel Management in order to assist us in developing a strategy that enables us to unify and streamline recruitment and retention across all specialties and skill sets. We must implement a "lifecycle management" approach to our human capital, to include all corps of each Service, all skill sets, and civilians. In order to compete with the civilian sector, each Service needs to be able to run our own bonus and compensation structure and tailor our own programs in order to compete for quality people in each of our unique environments and market places. Having a one-size-fits-each-Service policy is too constrictive and does not help.

5. Medical Military Construction (MILCON) - We are halfway through the greatest medical infrastructure reset in our lifetimes, and this is a great opportunity to set the medical infrastructure conditions for the next two generations of Soldiers. We must be successful and this must remain a key focus for us. HA has played a visionary and courageous role in this effort. We need a comprehensive and strongly supported approach from DoD to protect us from the danger of short-term thinking about the long-term medical MILCON needs. HA can help us garner and prioritize MILCON resources and/or funding to create a medical infrastructure that meets the demands of our beneficiary population. HA should facilitate an integrated MILCON infrastructure to support "centers of care" in geographical locations to meet increased health care demands and ensure the efficient use of resources.

6. Joint Governance - If we are to have integrated service medical platforms (like the San Antonio Military Medical Community, the Military Education and Training Center, Joint Task Force CAPMED, and the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury), we need to have a way to connect those platforms across the Services to policy and strategic leadership levels. We need to re-establish roles and clarify missions.

Draw the lines in bold colors among the Services, TMA, and HA. Currently, within the MHS, each of the three Services and HA/TMA engage tactical challenges parochially. Too often, we avoid true strategic engagement which compromises trust and has a suboptimal effect on ensuring the desired outcomes. There is no standardized approach or roadmap on how to establish joint governance, and each area is being handled differently. Nonetheless, the Services have come together as partners and we are making progress toward integrated operations while still maintaining Service identity.

Collaborating and sharing resources across the joint services makes absolute sense, but we must establish a methodology to ease the transition without sacrificing our Title 10 responsibilities. Command and Control, establishing an approved joint manning document to assign personnel to joint organizations, and ensuring the leadership of joint organizations represent the interests of all the Services are issues that we need to address at the HA level.

7. Standardized Approach to Preventive Medicine and Force Health Protection (FHP) - We must make the shift to a Preventive/Health Promotion Model, rather than continuing to provide reactive medical care with uncontrolled demand. This takes adequate resourcing, education of our staff and our beneficiaries, superb information systems, comprehensive population health surveillance, and well-documented care. While strategically engaged with prevention and FHP measures, we cannot lessen or dilute the attention given to evidence-based practices and science-driven improvements in interventional care directed at optimal clinical outcomes. Again, standardization of clinical practices, shared metrics for measuring success across the Services, and an optimal EHR system are needed to make this happen. Acknowledging the importance of this shift, the MEDCOM is reorganizing to establish a Public Health Command which attends to comprehensive force health protection.

8. MHS Strategic Objective - The MHS has dramatically improved the identification and dissemination of system-wide performance expectations. What is now needed is further refinement of these objectives by providing more specificity in terms of what constitutes overall MHS system success and how

each Service can contribute in the form of actionable, leading metrics. We must maintain the proper balance between measures of process as lead indicators and outcome measures as lag indicators. We must establish metrics that measure whether a management strategy produces the desired outcomes. These metrics should address both clinical and administrative performance.

Health Affairs and TMA can help us by embracing a strategic intent that reflects what the MHS wants to achieve in the long term, as well as providing a sense of direction, discovery, and opportunity that can be communicated across the MHS to all employees. There is no more fertile time for this to occur than at this point in the Nation's examination of its healthcare delivery. HA's strategic intent should focus less on today's problems and more on tomorrow's opportunities. HA must develop policies and enabling systems which permit the Services to translate the MHS strategy into action.

Unfortunately, none of these issues is easy—they are all complex, inter-related problems that require thoughtful, collaborative, and sustained effort from all stakeholders in the MHS. Despite the difficulty and complexity of the challenge, I firmly believe that the MHS has the talent, the capability, and the commitment to achieve this vision, set a high standard for healthcare in the United States, and serve to inform the broader healthcare reform dialogue.

I would like to thank the Military Personnel Subcommittee for valuing the role of military medicine and the vital importance of robust direct care systems and for supporting our continuing efforts to improve. Health Affairs plays a critical role in the success of the Service Medical Departments. By focusing on its roles of policy development and strategic leadership, and by operating in an open and transparent manner, Health Affairs can continue to add tremendous value to the MHS and, most importantly, meet the healthcare needs of the finest beneficiaries in the world—the men and women of the US military.